NOTE: **Self Insured Employer**
Complete this page on ALL reports.

Year Ending **December 31, 1997**

State of California
Department of Industrial Relations
Self Insurance Plans
2265 Watt Avenue, Suite 1
Sacramento, CA 95825
Form A4-40a (4/92)

PRIVATE SELF INSURER'S ANNUAL REPORT

I. GENERAL

1. CERTIFICATE NUMBER: ☐-☐☐☐☐-☐☐-☐☐☐
☐ Active ☐ Revoked

2. PERIOD OF REPORT:
☐ Full Year ☐ Interim Report for the Period of:
☐☐☐☐☐☐ (Month Day Year) to ☐☐☐☐☐☐ (Month Day Year)

3. NAME OF MASTER CERTIFICATE HOLDER:

NAME

ADDRESS

CITY STATE ZIP + 4

State of Incorporation: ☐☐

Federal Tax Identification No.:

First 4 Digits of Your Standard Industrial Classification (SIC) Code: ☐☐☐☐

4. List names of ALL separate, but affiliated or subsidiary companies covered by this certificate (do not include DBAs or operating divisions):

FULL LEGAL NAME	STATE OF INCORPORATION	SUBSIDIARY/AFFILIATE CERTIFICATE NUMBER
	☐☐	☐☐☐☐-☐☐
	☐☐	☐☐☐☐-☐☐
	☐☐	☐☐☐☐-☐☐
	☐☐	☐☐☐☐-☐☐
	☐☐	☐☐☐☐-☐☐
	☐☐	☐☐☐☐-☐☐
	☐☐	☐☐☐☐-☐☐
	☐☐	☐☐☐☐-☐☐
	☐☐	☐☐☐☐-☐☐
	☐☐	☐☐☐☐-☐☐

(Continue on reverse side of this page if necessary.)

5. During the reporting period of this report, has there been any of the following with respect to the Master Certificate Holder or any subsidiary?

(a) Reincorporating	☐ Yes	☐ No
(b) Merger	☐ Yes	☐ No
(c) Change in Identity	☐ Yes	☐ No
(d) Any additions to Self Insurance Program	☐ Yes	☐ No

(Continue on reverse side of this page if necessary.)

6. TO WHOM DO YOU WANT CORRESPONDENCE ADDRESSED?

NAME/TITLE:

COMPANY NAME:

ADDRESS:

CITY: STATE: ZIP+4:

TELEPHONE: ( ) FACSIMILE (FAX) NUMBER: ( )

SUBMIT TWO (2) COMPLETE REPORTS OF PAGES 1 THROUGH 6, INCLUDING:
• LIST OF OPEN INDEMNITY CLAIMS
• SPECIFIC EXCESS INSURANCE POLICY COVERAGE PAGE

REPORT IS DUE MARCH 1, 1998

4. (Continued)

FULL LEGAL NAME	STATE OF INCORPORATION	SUBSIDIARY/AFFILIATE CERTIFICATE NUMBER

5. (Continued)

NOTE: **Claims Administrator**
Complete this page for ALL reports except Item B Employment/Wages, which is completed by Self Insured Employer.

II. CONSOLIDATED LIABILITIES

Certificate Number: ☐-☐☐☐☐-☐☐-☐☐☐

Name of Master Certificate Holder: _____

Type of Report:

☐ Original Report (Due March each year) ☐ Amended Report ☐ Interim Report

From Date: ☐☐ Month ☐☐ Day ☐☐ Year To Date: ☐☐ Month ☐☐ Day ☐☐ Year

A. CASES AND BENEFITS (to nearest dollar)

	Number	Incurred Liability		Paid to Date		Future Liability	
		$ Indemnity	$ Medical	$ Indemnity	$ Medical	$ Indemnity	$ Medical
1. Cases open as of 12/31/97 reported prior to 1993							
2. Open & Closed Cases:							
a. All cases reported in 1993							
1993 Cases open							
b. All cases reported in 1994							
1994 Cases open							
c. All cases reported in 1995							
1995 Cases open							
d. All cases reported in 1996							
1996 Cases open							
e. All cases reported in 1997							
1997 Cases open							

	$ Indemnity	$ Medical
SUBTOTAL		
TOTAL		

3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical)

$ Indemnity	$ Medical

4. Total Benefits paid during 1997 (including all case expenditures): . . . . . _____

5. Number of MEDICAL-ONLY cases reported in 1997: . . . . . _____

6. Number of INDEMNITY cases reported in 1997: . . . . . _____

7. TOTAL of 5 and 6 (also entered in 2e above): . . . . . _____

8. TOTAL number of open indemnity cases (all years): . . . . . _____

9. Number of Fatality cases reported in 1997: . . . . . _____

10. (a) Number of 1997 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 1997: . . . . _____

10. (b) Number of non-1997 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 1997: . . . . _____

B. EMPLOYMENT AND WAGES PAID IN CALENDAR YEAR 1997:

(a) NUMBER OF EMPLOYEES _____
(For which a W-2 Tax Form was issued for California employment in Calendar Year 1997)

(b) TOTAL WAGES AND SALARIES PAID $ _____
(As reported on EDD Form DE-3DP Line B for all four quarters)

IIA. ADMINISTRATOR

A. NAME OF CURRENT ADMINISTRATOR(S)/ADMINISTRATING AGENCY(S) AT THE TIME OF PREPARING THIS REPORT.

1. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** ____ **Zip+4** _____

2. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** ____ **Zip+4** _____

3. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** ____ **Zip+4** _____

4. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** ____ **Zip+4** _____

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THE PERIOD OF THIS REPORT PERIOD? ☐ **YES** ☐ **NO** **IF YES, DATE OF CHANGE:** ☐☐☐☐☐☐ (Month Day Year)

TYPE OF CHANGE: ☐ **Change in Administrative Agency**

☐ **Change to or from Self Administration**

C. NAME OF PRIOR ADMINISTRATOR(S)/ADMINISITRATIVE AGENCY(S):

Name _____

Agency Name _____

Address _____

City _____ **State** ____ **Zip+4** _____

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this consolidated report of this self insurer's workers' compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers' compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers' compensation claims made in this report reflect the administrator's best judgment as to the future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

_____ _____

Original Signature of Administrator (Person) **Date**

_____ _____

Typed Name of Administrator **Name of Administrative Agency or Employer**

_____ _____

Title **Street Address**

_____

City **State** **Zip+4**

Phone No. of Administrator (**)** _____ **FAX No. (** **)** _____

area code **area code**

NOTE: **Claims Administrator**
Complete this page for ***each adjusting*** *location where there are at least two adjusting locations.*

III. LIABILITIES BY REPORTING LOCATION

Reporting Location Nos.: ☐-☐☐☐☐-☐☐-☐☐☐

Name/Identification of Location: _____

Name of Master Certificate Holder: _____

Type of Report:

☐ Original Report (Due March each year) ☐ Amended Report ☐ Interim Report

From Date: ☐☐ Month ☐☐ Day ☐☐ Year To Date: ☐☐ Month ☐☐ Day ☐☐ Year

A. CASES AND BENEFITS (to nearest dollar)

	Number	Incurred Liability		Paid to Date		Future Liability	
		$ Indemnity	$ Medical	$ Indemnity	$ Medical	$ Indemnity	$ Medical
1. Cases open as of 12/31/97 reported prior to 1993							
2. Open & Closed Cases:							
a. All cases reported in 1993							
1993 Cases open							
b. All cases reported in 1994							
1994 Cases open							
c. All cases reported in 1995							
1995 Cases open							
d. All cases reported in 1996							
1996 Cases open							
e. All cases reported in 1997							
1997 Cases open							

	$ Indemnity	$ Medical
SUBTOTAL		
3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical) **TOTAL**		

	$ Indemnity	$ Medical
4. Total Benefits paid during 1997 (including all case expenditures):		

5. Number of MEDICAL-ONLY cases reported in 1997: _____

6. Number of INDEMNITY cases reported in 1997: _____

7. TOTAL of 5 and 6 (also entered in 2e above): _____

8. TOTAL number of open indemnity cases (all years): _____

9. Number of Fatality cases reported in 1997: _____

10. (a) Number of 1997 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 1997: _____

10. (b) Number of non-1997 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 1997: _____

A. NAME OF CURRENT ADMINISTRATOR(S)/ADMINISTRATING AGENCY(S) AT THE TIME OF PREPARING THIS REPORT**.**

1. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** ____ **Zip+4** _____

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THE PERIOD OF THIS REPORT PERIOD? ☐ **YES** ☐ **NO** **IF YES, DATE OF CHANGE:** ☐☐☐☐☐☐ Month Day Year

TYPE OF CHANGE: ☐ **Change in Administrative Agency**

☐ **Change to or from Self Administration**

C. NAME OF PRIOR ADMINISTRATOR(S)/ADMINISITRATIVE AGENCY(S):

Name _____

Agency Name _____

Address _____

City _____ **State** ____ **Zip+4** _____

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this consolidated report of this self insurer's workers' compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers' compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers' compensation claims made in this report reflect the administrator's best judgment as to the future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

_____ _____

Original Signature of Administrator (Person) **Date**

_____ _____

Typed Name of Administrator **Name of Administrative Agency or Employer**

_____ _____

Title **Street Address**

_____

City **State** **Zip+4**

Phone No. of Administrator ( ) **FAX No. ( )**

area code **area code**

IV. RECORDS STORAGE

1. Are claim records stored at any location other than with the current administrator?

☐ **Yes** ☐ **No** **If yes, Where?** _____

A. Agency Name _____
Address _____
City _____ **State** ___ **Zip+4** _____
Phone (___ **)** _____

B. Agency Name _____
Address _____
City _____ **State** ___ **Zip+4** _____
Phone (___ **)** _____

C. Agency Name _____
Address _____
City _____ **State** ___ **Zip+4** _____
Phone (___ **)** _____

D. Agency Name _____
Address _____
City _____ **State** ___ **Zip+4** _____
Phone (___ **)** _____

V. INSURANCE COVERAGE

1. Are any of your workers' compensation liabilities in California during the reporting period covered by a standard workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:**

1. Name of Insurance Company: _____
Policy Number: _____ **Policy Issue Date:** _____

2. Name of Insurance Company: _____
Policy Number: _____ **Policy Issue Date:** _____

2. Are any of your workers' compensation liabilities in California during the reporting period covered by a specific excess workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:**

1. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

2. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

3. Do you carry an aggregate (stop loss) workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:**

1. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

2. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

VI. OPEN INDEMNITY CLAIMS AND CLAIM LOG

A. List of *ALL* Open Indemnity Claims (by reporting location and by year) reported and with claims (in alphabetical order) is attached immediately following page 7 of this report.
(You may use the form attached or a computer-prepared printout organized in the same format.)

B. Specific Excess Insurance Policy Pages

ATTACHMENTS:

1. **List of Open Indemnity Claims (See instructions under Section VI.)**
2. **Specific Excess Insurance Policy Pages**

VII. SECURITY DEPOSIT

Certificate Number: ☐-☐☐☐☐-☐☐-☐☐☐

Name of Certificate Holder: _____

A. CURRENT TYPE(S) OF DEPOSIT: Check applicable type(s) of security deposit and provide information on each type of deposit posted with the State of California as of cutoff date of report (i.e. for full year report, as of December 31, 1997.)

☐ **Surety Bond (s)**

Carrier Name	Bond #	Original Issue Date	Active or Cancelled	Penal Sum of Bond
				$
				$
				$
			Surety Bonds Total	$

☐ **Letters of Credit**

Bank Name	Letter of Credit #	Type Issuing/Confirm	Total Letter of Credit Amount
			$
			$
			$
		Letters of Credit Total	$

☐ **Securities**

Issue Name	Type R-Registered BE-Book Entry	ID/or CUSIP #	Interest Rate	Date Issued & Maturity	$ Par Value
					$
					$
					$
					$
					$
					$
					$
					$
				Securities Total	$

☐ **Cash, Certificate (s) of Deposit**

Deposit Institution	Account Number	Type Cash/CD	Date Deposited	Amount
				$
				$
				$
				$
			Cash/CD Total	$

LINE AA: TOTAL DEPOSIT ALL TYPES $_____

VIII. DEPOSIT CALCULATION

A. Estimated Future Liability
(From Line 3 of Consolidated Liabilities on Page 2) . . . . . _____

B. Minimum Deposit Factor—Known Claims . . . . . x 135%

Indicate Minimum Deposit Required . . . . . **Line BB $** _____

C. Add Deposit for Current Year:

(1) Estimated Future Liability
(From Line A above) $ _____

(2) Less Future Liability of cases prior to 1993
(From Line 1 of Consolidated Liabilities on Page 2) - $ _____

$ Indemnity	+	$ Medical

(3) 5 year total unpaid Future Liability = $ _____

(4) One year average unpaid liability (Divide Line 3 above by "5") ÷ 5 . . . . . **Line CC $** _____

(5) Subtotal (Add Line BB and Line CC) . . . . . **Subtotal $** _____

D. Total Adjustment for Excess Coverage . . . . . - $ _____

Adjusted Total . . . . . **Line DD $** _____

E. Total Deposit All Types (Line AA, Part VII, previous page) . . . . . Line AA $ _____

Minimum Deposit Increase Indicated (Line DD—Line AA) . . . . . $ _____
Increase is Due by May 1.

Minimum Deposit Decrease Indicated (Line DD—Line AA) . . . . . $ **(** _____ **)**

NOTE: **Labor Code Section 3701(a) requires every private, self-insuring employer to secure incurred liabilities for the payment of compensation by renewing or making a new deposit of security within 60 days of filing of this annual report, but in no event later than May 1 of each year. Civil penalties of up to $5,000 for every 30 days or portion thereof that there is a failure to post deposit may be assessed by the Director of Industrial Relations pursuant to Labor Code Section 3702.9 for failure to post required deposit when due.**

CERTIFICATE OF COMPANY OFFICER

I declare under the penalty of perjury that I have examined this Self Insurer's Annual Report and to the best of my knowledge and belief it is true, correct and complete. I am also aware of our company's duty to post and maintain the required security deposit that is due as a result of this report.

_____ _____
Signature of Company Officer **Date**

_____ _____
Typed Name of Company Officer **Name of Company**

_____ _____
Title **Street Address**

_____
City **State** **Zip+4**

Phone No. (**)** _____
area code

SPECIFIC EXCESS INSURANCE POLICY COVERAGE

Certificate No: ______________________ **Name of Self Insurer:** ______________________________________

Note: **Instructions to Claims Administrator—See Reverse Side of this Page.**

Name of Claimant	Claim No.	Date of Injury	First Year Reported **To SIP**
Description of Injury		Name of Specific Excess Carrier	
Policy Number	**Policy Period** **From:** **To:**	**Retention Level of Policy** **Min $** **Max $**	

Claim Reported to Carrier? ☐ Yes ☐ No
Claim Acknowledged/Accepted by Carrier? ☐ Yes ☐ No
Has carrier denied any part or all liability of this claim? ☐ Yes ☐ No
Total of payment by excess carrier to date of this claim: $

Estimated Future Liability	- Total Unpaid Employer Retention	Total Unpaid Carrier Liability

Name of Claimant	Claim No.	Date of Injury	First Year Reported **To SIP**
Description of Injury		Name of Specific Excess Carrier	
Policy Number	**Policy Period** **From:** **To:**	**Retention Level of Policy** **Min $** **Max $**	

Claim Reported to Carrier? ☐ Yes ☐ No
Claim Acknowledged/Accepted by Carrier? ☐ Yes ☐ No
Has carrier denied any part or all liability of this claim? ☐ Yes ☐ No
Total of payment by excess carrier to date of this claim: $

Estimated Future Liability	- Total Unpaid Employer Retention	Total Unpaid Carrier Liability

Name of Claimant	Claim No.	Date of Injury	First Year Reported **To SIP**
Description of Injury		Name of Specific Excess Carrier	
Policy Number	**Policy Period** **From:** **To:**	**Retention Level of Policy** **Min $** **Max $**	

Claim Reported to Carrier? ☐ Yes ☐ No
Claim Acknowledged/Accepted by Carrier? ☐ Yes ☐ No
Has carrier denied any part or all liability of this claim? ☐ Yes ☐ No
Total of payment by excess carrier to date of this claim: $

Estimated Future Liability	- Total Unpaid Employer Retention	Total Unpaid Carrier Liability

Name of Claimant	Claim No.	Date of Injury	First Year Reported **To SIP**
Description of Injury		Name of Specific Excess Carrier	
Policy Number	**Policy Period** **From:** **To:**	**Retention Level of Policy** **Min $** **Max $**	

Claim Reported to Carrier? ☐ Yes ☐ No
Claim Acknowledged/Accepted by Carrier? ☐ Yes ☐ No
Has carrier denied any part or all liability of this claim? ☐ Yes ☐ No
Total of payment by excess carrier to date of this claim: $

Estimated Future Liability	- Total Unpaid Employer Retention	Total Unpaid Carrier Liability

SUBTOTAL Total Unpaid Carrier Liability This Page: $ ____________

Instructions to Claims Administrator

Complete all the information requested on each claim that has estimated incurred liability greater than the minimum retention level of the specific excess insurance policy.

Add the subtotaled carrier liability for all pages necessary to list the claims in excess coverage and then complete the backside of this form on the last page of the specific excess insurance policy coverage pages in order to calculate the adjustment figure of Specific Excess Coverage to enter on Page 6, Line D of the Self Insurer's Annual Report.

Submit the completed page or pages as Section B of the Part 6, List of Open Indemnity Claims, for each Annual Report.

Note: You may use this form or a computerized form displaying the same information in the same format.

Calculation of Specific Excess Coverage Entry for Annual Report:

1. Total of Carrier Liability Listed on All Pages of "Specific Excess Insurance Policy Coverage" pages attached hereto: **$** _____

2. Enter Deposit Rate Applicable for This Self Insurer: **X** _____

3. Multiply Line 1 Figure times Deposit Rate and Enter Specific Excess Insurance Adjustment: **$** _____

4. Enter Adjustment Figure on Line 3 above on Page 6, Line D.

LIST OF OPEN INDEMNITY CASES
AS OF_____

Reporting Location No.: _____

Certificate Number: _____

All Cases on this Page are
For the Year _____

NAME OF MASTER CERTIFICATE HOLDER: _____

Name of Insured or Deceased (Last) (First Initial)	Date of Injury	Description of Injury	Paid to Date		Estimated Future Liability	
			Indemnity	Medical	Indemnity	Medical
(List Alphabetically within year)						